FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038612

Facility Name: WATERFORD, THE

Address: 7445 N. SHERIDAN RD. (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: (773) 338-3300 **Fax #** (773) 338-5868

IDPA ID Number: 363853042001

Date of Initial License for Current Owners: 07/01/82

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) DONALD MAGNUSON, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds NA

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	51	Skilled (SNF)	51	18,615	1
2		Skilled Pediatric (SNF/PED)			2
3	98	Intermediate (ICF)	98	35,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	149	TOTALS	149	54,385	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,528	707	534	8,769	8
9	SNF/PED					9
10	ICF	20,516	1,714		22,230	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,044	2,421	534	30,999	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.00%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NA

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/82

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/82 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 479

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	150,055	13,329	4,561	167,945		167,945		167,945			1
2	Food Purchase		170,677		170,677	(32,412)	138,265	(133)	138,132			2
3	Housekeeping	72,944	14,573		87,517		87,517		87,517			3
4	Laundry	47,081	10,239		57,320		57,320		57,320			4
5	Heat and Other Utilities			112,161	112,161		112,161		112,161			5
6	Maintenance	30,908	13,049	88,260	132,217		132,217	(31,527)	100,690			6
7	Other (specify):*											7
8	TOTAL General Services	300,988	221,867	204,982	727,837	(32,412)	695,425	(31,660)	663,765			8
	B. Health Care and Programs											
9	Medical Director			3,900	3,900		3,900		3,900			9
10	Nursing and Medical Records	711,189	34,895	123,800	869,884		869,884		869,884			10
10a	Therapy	42,298		3,259	45,557		45,557		45,557			10a
11	Activities	48,193		4,510	52,703		52,703		52,703			11
12	Social Services	26,247	3,266	3,888	33,401		33,401		33,401			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	827,927	38,161	139,357	1,005,445		1,005,445		1,005,445			16
	C. General Administration											
17	Administrative	62,190		211,993	274,183		274,183	6,814	280,997			17
18	Directors Fees											18
19	Professional Services			127,041	127,041		127,041	(2,485)	124,556			19
20	Dues, Fees, Subscriptions & Promotions			46,800	46,800		46,800	(38,478)	8,322			20
21	Clerical & General Office Expenses	90,783	16,810	121,047	228,640		228,640	(99,034)	129,606			21
22	Employee Benefits & Payroll Taxes			217,780	217,780	32,412	250,192	(8,250)	241,942			22
23	Inservice Training & Education											23
24	Travel and Seminar			989	989		989		989			24
25	Other Admin. Staff Transportation			569	569		569		569			25
26	Insurance-Prop.Liab.Malpractice			79,456	79,456		79,456		79,456			26
27	Other (specify):*							493	493			27
28	TOTAL General Administration	152,973	16,810	805,675	975,458	32,412	1,007,870	(140,940)	866,930			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,281,888	276,838	1,150,014	2,708,740		2,708,740	(172,600)	2,536,140			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WATERFORD, THE #0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			44,584	44,584		44,584	23,514	68,098			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,083	21,083		21,083	112,504	133,587			32
33	Real Estate Taxes							115,462	115,462			33
34	Rent-Facility & Grounds			523,350	523,350		523,350	(523,350)				34
35	Rent-Equipment & Vehicles			750	750		750		750			35
36	Other (specify):*											36
37	**TOTAL Ownership**			589,767	589,767		589,767	(271,870)	317,897			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		14,493	41,517	56,010		56,010		56,010			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,577	81,577		81,577		81,577			42
43	Other (specify):*	29,833			29,833		29,833	(29,833)				43
44	**TOTAL Special Cost Centers**	29,833	14,493	123,094	167,420		167,420	(29,833)	137,587			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,311,721	291,331	1,862,875	3,465,927		3,465,927	(474,303)	2,991,624			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,287	30		9
10	Interest and Other Investment Income	(73,519)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(133)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(593)	21		18
19	Entertainment	(2,441)	21		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance	(8,250)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(96,000)	21		24
25	Fund Raising, Advertising and Promotional	(24,649)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(84,232)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (281,030)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(193,273)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (193,273)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (474,303)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WATERFORD, THE

ID# 0038612

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PROFESSIONAL FEES-BUILDING PTRSHP	$ (1,200)	19	1
2	COPE (POLITICAL EDUCATION)	(3,329)	20	2
3	POLITICAL CONTRIBUTIONS	(10,000)	20	3
4	ASSET ON CR. EXP ON FS	(31,527)	6	4
5	AMORTIZATION OF MORTGAGE FEE	(5,858)	36	5
6	MARKETING SALARY	(29,833)	43	6
7	PRIOR YEAR LEGAL	(2,485)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(133)											(133)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(31,527)											(31,527)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(31,660)											(31,660)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			6,814									6,814	17
18	Directors Fees													18
19	Professional Services	(3,685)	1,200										(2,485)	19
20	Fees, Subscriptions & Promotions	(38,478)											(38,478)	20
21	Clerical & General Office Expenses	(99,034)											(99,034)	21
22	Employee Benefits & Payroll Taxes	(8,250)											(8,250)	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*			493									493	27
28	**TOTAL General Administration**	(149,447)	1,200	7,307									(140,940)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(181,107)	1,200	7,307									(172,600)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	9,287	14,227										23,514	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(73,519)	186,023										112,504	32
33	Real Estate Taxes		115,462										115,462	33
34	Rent-Facility & Grounds		(523,350)										(523,350)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(5,858)	5,858											36
37	TOTAL Ownership	(70,090)	(201,780)										(271,870)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(29,833)											(29,833)	43
44	TOTAL Special Cost Centers	(29,833)											(29,833)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(281,030)	(200,580)	7,307									(474,303)	45

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		PRO HEALTHCARE	BUFFALO GROVE	MGMT CO
				DEAUVILLE	CHICAGO	BUILDING CO
				HEALTHCARE		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 407,888	DEAUVILLE HEALTHCARE	100.00%	$	$ (407,888)	1
2	V	34	RENT-REAL ESTATE TAX	115,462	DEAUVILLE HEALTHCARE	100.00%		(115,462)	2
3	V	19	PROFESSIONAL FEES		DEAUVILLE HEALTHCARE	100.00%	1,200	1,200	3
4	V	33	REAL ESTATE TAX		DEAUVILLE HEALTHCARE	100.00%	166,346	166,346	4
5	V	33	REAL ESTATE TAX-PR YR		DEAUVILLE HEALTHCARE	100.00%	(50,884)	(50,884)	5
6	V	30	DEPRECIATION		DEAUVILLE HEALTHCARE	100.00%	14,227	14,227	6
7	V	32	INTEREST EXPENSE		DEAUVILLE HEALTHCARE	100.00%	186,063	186,063	7
8	V	36	AMORT. OF MORT. COST		DEAUVILLE HEALTHCARE	100.00%	5,858	5,858	8
9	V	32	INTEREST INCOME		DEAUVILLE HEALTHCARE	100.00%	(40)	(40)	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 523,350			$ 322,770	$ * (200,580)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY - STAN ARON	$	PRO HEALTH CARE, INC.	100.00%	$ 13,294	$ 13,294	15
16	V	27	PAYROLL TAXES			100.00%	493	493	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V	17	MANAGEMENT FEES	6,480		100.00%		(6,480)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,480			$ 13,787	$ * 7,307	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STAN ARON	OWNER	ADMIN	7.22%	SEE ATTACHED	3	4.62%	ALLOC-PRO	$ 13,294	17-7	1
2	SYLVIA HERLIHY	ADMINISTRATIVE	ADMIN	NONE	SEE ATTACHED	20	33.33%				2
3	ARI SHABAT	ASSIST ADMIN	ADMIN	NONE	SEE ATTACHED	40	72.73%	SALARY	12,922	17-1	3
4	DANIEL SHABAT	OWNER	ADMIN	18.05%	SEE ATTACHED	35	58.33%	MGMT FEE	205,513	17-3	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 231,729		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRO HEALTH CARE, INC. C/O FR&R
Street Address: 111 PFINGSTEN ROAD
City / State / Zip Code: DEERFIELD, IL 60115
Phone Number: (847)236-1111
Fax Number: (847)236-1155

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY - STAN ARON	AVG. HOURS WORKED	51	4	$ 226,000	$ 226,000	3	$ 13,294	1
2	27	PAYROLL TAXES	AVG. HOURS WORKED	51	4	8,372		3	493	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 234,372	$ 226,000		$ 13,787	25

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	ROYAL GARDENS		X	MORTGAGE	$10,458	10/01/90	$ 2,361,650	$ 743,401	08/01/11	11.00%	$ 83,894	1
2	MID NORTH		X	MORTGAGE	$22,733	11/01/90	2,000,000	849,780	11/01/05	11.00%	102,169	2
3	1ST BANK OF EVANSTON		X	AUTO LOAN	$855	11/01/99	18,800		11/01/01	8.50%	359	3
4												4
5												5
	Working Capital											
6	SHAREHOLDER LOAN	X		WORKING CAPITAL	NONE	11/01/92	500,000	500,000	12/31/01	IRS RATE	20,724	6
7												7
8												8
9	TOTAL Facility Related				$34,046		$ 4,880,450	$ 2,093,181			$ 207,146	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	INTEREST INCOME										(73,519)	11
12	ALLOC INT. INC-DEAU HC										(40)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (73,559)	14
15	TOTALS (line 9+line14)						$ 4,880,450	$ 2,093,181			$ 133,587	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	212,384	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	161,501	2
3. Under or (over) accrual (line 2 minus line 1).	$	(50,883)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	166,346	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	115,463	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	203,400	8
	1997	203,971	9
	1998	207,591	10
	1999	206,198	11
	2000	161,501	12

2001 ACCRUAL INCREASED 3% FOR INFLATION : 161,501 * 1.03 = 166,346

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WATERFORD, THE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0038612

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-29-308-005-0000	LONG TERM CARE PROPERTY	$ 161,501.00	$ 161,501.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 161,501.00	$ 161,501.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,216 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NA

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 196,188	1
2					2
3	TOTALS			$ 196,188	3

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	149			1984	$ 2,183,550	$	35	$	$	$ 2,183,550	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	63,831		20	3,192	3,192	25,839	9
10	Various			1994	33,446		20	1,672	1,672	12,813	10
11	Various			1995	40,581		20	2,029	2,029	13,845	11
12	Various			1996	19,396		20	971	(971)	5,517	12
13	Various			1997	99,588		20	4,980	4,980	22,972	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		279,801	7,935		9,923	1,988	219,719	68
69	Financial Statement Depreciation			6,670			(6,670)		69
70	TOTAL (lines 4 thru 69)		$ 2,720,193	$ 14,605		$ 22,767	$ 6,220	$ 2,484,255	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,720,193	$ 14,605		$ 22,767	$ 8,162	$ 2,484,255	1
2	SAFETY CODE REVIEW	1998	2,252		20	113	113	452	2
3	MAGNET DOOR	1998	800		20	40	40	157	3
4	SUMP PUMP	1998	2,500		20	125	125	490	4
5	PATIENT DOORS	1998	3,680		20	184	184	690	5
6	BATHROOM DOORS	1998	1,185		20	59	59	221	6
7	GENERATOR-100 AMP	1998	3,145		20	157	157	589	7
8	PLUMBING-PIPES	1998	975		20	49	49	172	8
9	PARKING-ASPHALT	1998	2,833		20	142	142	509	9
10	FIRE DAMPERS	1998	1,528		20	76	76	253	10
11	ELECTRICAL LINES	1998	975		20	49	49	159	11
12	STAIRWAY RAILINGS	1998	660		20	33	33	102	12
13	FIRERATED DOOR	1998	750		20	38	38	120	13
14	WALLPAPER	1998	1,000		20	50	50	192	14
15	ELEVATOR DOOR RESTRI	1998	2,400		20	120	120	440	15
16	ELEV.INFRARED DOOR	1998	1,750		20	88	88	301	16
17	WALLPAPER	1999			20				17
18	FIRE DAMPERS	1999	1,750		20	88	88	257	18
19	DRYWALL	1999	2,800		20	140	140	408	19
20	FIRE DAMPERS	1999	5,300		20	265	265	751	20
21	DRYWALL	1999	630		20	32	32	88	21
22	BASE DRYWALL	1999	722		20	36	36	93	22
23	ELECTRIC OUTLET	1999	650		20	33	33	77	23
24	DOORS	1999	3,465		20	173	173	404	24
25	DOORS	1999	5,280		20	264	264	616	25
26	BATH TUB IMPROVEMENT	1999	1,550		20	78	78	208	26
27	HOSPICE REMODELING	1999	4,000		20	200	200	433	27
28	ARCHITECT	1999	834		20	42	42	119	28
29	ARCHITECT	1999	3,103		20	155	155	426	29
30	PAINTING	1999	18,828		20	941	941	1,960	30
31	WALLPAPER	1999	3,172		20	159	159	411	31
32	WALLPAPER	1999	2,878		20	144	144	360	32
33	WALLPAPER	1999	480		20	24	24	54	33
34	TOTAL (lines 1 thru 33)		$ 2,802,068	$ 14,605		$ 26,864	$ 12,259	$ 2,495,767	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,802,068	$ 14,605		$ 26,864	$ 12,259	$ 2,495,767	1
2	NURSING STATION	1999	3,325		20	166	166	360	2
3	WALLPAPER	1999	190		20	10	10	24	3
4	CARPET	1999	802		20	40	40	97	4
5	DRAPERIES	1999	437		20	22	22	53	5
6	WALLPAPER	1999	4,814		20	241	241	562	6
7	WALLPAPER	1999	1,584		20	79	79	184	7
8	WINDOW TREATMENT	1999	13,458		20	673	673	1,570	8
9	CORRIDOR RAILINGS	2000	5,913		20	296	296	370	9
10	CORRIDOR RAILINGS	2000	11,473		20	574	574	622	10
11	WARDROBES	2000	16,660		20	833	833	1,111	11
12	HOT WATER HEATER	2000	3,860		20	193	193	370	12
13	DOOR	2000	806		20	40	40	77	13
14	DOORS	2000	1,500		20	75	75	144	14
15	LIGHT FIXTURES	2000	875		20	44	44	81	15
16	GENERATOR DUCT	2000	750		20	38	38	70	16
17	BOILER RM INSULATION	2000	3,000		20	150	150	263	17
18	LIGHT FIXTURES	2000	2,250		20	113	113	188	18
19	KEYPAD ALARM	2000	891		20	45	45	71	19
20	GENERATOR DUCT	2000	750		20	38	38	70	20
21	BOILER ROOM PIPING	2000	2,000		20	100	100	192	21
22	TOILET	2000	525		20	26	26	30	22
23	ELEVATOR MOTOR	2000	1,065		20	53	53	80	23
24	WINDOW TREATMENT	2000	9,455		20	473	473	946	24
25	CURTAINS	2000	4,908		20	245	245	490	25
26	PAINTING	2000	574		20	29	29	53	26
27	CARPETING	2000	601		20	30	30	55	27
28	PAINTING	2000	916		20	46	46	81	28
29	PAINTING	2000	179		20	9	9	16	29
30	DECORATING	2000	308		20	15	15	26	30
31	PAINTING	2000	90		20	5	5	8	31
32	CARPET BORDER	2000	44		20	2	2	3	32
33	DECORATING	2000	400		20	20	20	32	33
34	TOTAL (lines 1 thru 33)		$ 2,896,471	$ 14,605		$ 31,587	$ 16,982	$ 2,504,066	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,896,471	$ 14,605		$ 31,587	$ 16,982	$ 2,504,066	1
2	CARPET BORDER	2000	46		20	2	2	3	2
3	PAINTING	2000	226		20	11	11	17	3
4	DECORATING	2000	100		20	5	5	8	4
5	PAINTING	2000	574		20	29	29	44	5
6	WALL-BASE COVERING	2000	305		20	15	15	23	6
7	PAINTING	2000	690		20	35	35	53	7
8	PAINTING	2000	650		20	33	33	50	8
9	PAINTING	2000	800		20	40	40	60	9
10	WALL-BASE COVERING	2000	305		20	15	15	21	10
11	TILE	2000	7,764		20	388	388	550	11
12	FLOORING	2000	1,408		20	70	70	99	12
13	PAINTING	2000	600		20	30	30	45	13
14	WALL COVE BASE	2000	113		20	6	6	8	14
15	PAINTING	2000	400		20	20	20	27	15
16	WALLPAPER	2000	1,680		20	84	84	105	16
17	WALLPAPER	2000	1,995		20	100	100	108	17
18	PAINTING	2000	217		20	11	11	12	18
19	TILE	2001	7,478		20	125	125	125	19
20	STEEL FRAME-DAYROOM	2001	8,833		20	111	111	111	20
21	LOCKS & ELEV SYS	2001	5,566		20	162	162	162	21
22	FRONT AWNING	2001	2,710		20	45	45	45	22
23	RECEPTION DESK	2001	8,378		20	70	70	70	23
24	FENCE	2001	595		20	18	18	18	24
25	SIGN	2001	1,794		20	30	30	30	25
26	SHELVES & POSTS	2001	2,317		20	39	39	39	26
27	DRYER MOTOR	2001	657		20	33	33	33	27
28	HYDRAULIC PUMP	2001	986		20	41	41	41	28
29	ELETRIC LINE & MOTOR	2001	980		20	41	41	41	29
30	EXPANSION VALVE	2001	966		20	28	28	28	30
31	DUCT FITTING	2001	1,321		20	39	39	39	31
32	CONDENSER FAN MOTOR	2001	870		20	22	22	22	32
33	BLOWER BEARING	2001	968		20	24	24	24	33
34	TOTAL (lines 1 thru 33)		$ 2,958,763	$ 14,605		$ 33,309	$ 18,704	$ 2,506,127	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,958,763	$ 14,605		$ 33,309	$ 18,704	$ 2,506,127	1
2	GLASS WINDOWS	2001	800		20	13	13	13	2
3	BEARING ASSEMBLY	2001	639		20	8	8	8	3
4	PUMP MOTOR	2001	699		20	3	3	3	4
5	SIGN	2001	2,285		20	10	10	10	5
6	SUMP PUMP	2001	625		20	8	8	8	6
7	HOT WATER LINE	2001	4,500		20	19	19	19	7
8	REFINISH ELEV DOORS	2001	542		20	5	5	5	8
9	PAINTING	2001	1,000		20	8	8	8	9
10	WALLCOVER & PAINT	2001	3,744		20	47	47	47	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,973,597	$ 14,605		$ 33,430	$ 18,825	$ 2,506,248	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,973,597	$ 14,605		$ 33,430	$ 18,825	$ 2,506,248	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,973,597	$ 14,605		$ 33,430	$ 18,825	$ 2,506,248	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,973,597	$ 14,605		$ 33,430	$ 18,825	$ 2,506,248	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,973,597	$ 14,605		$ 33,430	$ 18,825	$ 2,506,248	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,973,597	$ 14,605		$ 33,430	$ 18,825	$ 2,506,248	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,973,597	$ 14,605		$ 33,430	$ 18,825	$ 2,506,248	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,973,597	$ 14,605		$ 33,430	$ 18,825	$ 2,506,248	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,973,597	$ 14,605		$ 33,430	$ 18,825	$ 2,506,248	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS-DEAUVILLE HAELTHCARE			1982	3,174		20			3,174	9
10	VARIOUS-DEAUVILLE HAELTHCARE			1983	22,098		20			22,098	10
11	VARIOUS-DEAUVILLE HAELTHCARE			1984	78,473	1,112	20	1,235	123	77,739	11
12	VARIOUS-DEAUVILLE HAELTHCARE			1985	65,697	3,416	20	3,458	(42)	56,227	12
13	VARIOUS-DEAUVILLE HAELTHCARE			1986	11,600	487	20	611	124	9,515	13
14	VARIOUS-DEAUVILLE HAELTHCARE			1987	17,548	557	20	557		8,077	14
15	VARIOUS-DEAUVILLE HAELTHCARE			1990	16,762	532	20	838	306	9,637	15
16	VARIOUS-DEAUVILLE HAELTHCARE			1991	36,643	1,163	20	1,833	670	20,089	16
17	VARIOUS-DEAUVILLE HAELTHCARE			1992	27,806	668	20	1,391	723	13,163	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 279,801	$ 7,935		$ 9,923	$ 1,904	$ 219,719	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 270,526	$ 25,122	$ 22,465	$ (2,657)	10	$ 148,737	71
72	Current Year Purchases	38,874	8,067	2,961	(5,106)	10	2,961	72
73	Fully Depreciated Assets	377,792	6,292	6,292		10	377,792	73
74								74
75	TOTALS	$ 687,192	$ 39,481	$ 31,718	$ (7,763)		$ 529,490	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Cadillac	1996	$ 25,000	$ 1,775	$	$ (1,775)	5	$ 25,000	76
77	Facility	AUTO	1999	18,800	2,950	2,950		5	8,890	77
78										78
79										79
80	TOTALS			$ 43,800	$ 4,725	$ 2,950	$ (1,775)		$ 33,890	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,900,777	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,811	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,098	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,287	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,069,628	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	EXCESS AUTO COST - 1996	$ 32,231	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 32,231	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 750 Description: PITNEY BOWES-POSTAL MACHINE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 19,020	$		$ 19,020	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			8,700			8,700	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			13,500			13,500	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				8,226		8,226	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					297	6,267		6,564	13
14	TOTAL			$		$ 41,517	$ 14,493		$ 56,010	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,553	$ 6,553	1
2	Cash-Patient Deposits	48,558	48,558	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	530,282	530,282	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	45,092	45,092	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,318,019	8
9	Other(specify): See supplemental schedule	184,341	345,872	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 814,826	$ 2,294,376	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		195,934	13
14	Buildings, at Historical Cost		2,211,665	14
15	Leasehold Improvements, at Historical Cost	268,795	519,737	15
16	Equipment, at Historical Cost	338,542	763,264	16
17	Accumulated Depreciation (book methods)	(242,117)	(3,054,255)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		23,457	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 365,220	$ 659,802	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,180,046	$ 2,954,178	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 134,062	$ 134,063	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	48,558	48,558	28
29	Short-Term Notes Payable	500,000	500,000	29
30	Accrued Salaries Payable	85,912	85,912	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,384	18,384	31
32	Accrued Real Estate Taxes(Sch.IX-B)		166,346	32
33	Accrued Interest Payable		14,604	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	46,900	46,900	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 833,816	$ 1,014,767	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,593,181	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule	361	361	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 361	$ 1,593,542	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 834,177	$ 2,608,309	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 345,869	$ 345,869	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,180,046	$ 2,954,178	48

*(See instructions.)

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 587,614	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 587,614	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(241,745)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (241,745)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 345,869	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,147,278	1
2	Discounts and Allowances for all Levels	(101,051)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,046,227	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	82,440	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 82,440	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	8,226	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,542	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,843	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,611	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	73,519	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 73,519	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	3,385	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,385	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,224,182	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	727,837	31
32	Health Care	1,005,445	32
33	General Administration	975,458	33
	B. Capital Expense		
34	Ownership	589,767	34
	C. Ancillary Expense		
35	Special Cost Centers	85,843	35
36	Provider Participation Fee	81,577	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,465,927	40
41	**Income before Income Taxes (line 30 minus line 40)****	(241,745)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (241,745)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,365	1,597	$ 37,311	$ 23.36	1
2	Assistant Director of Nursing	1,718	1,910	35,941	18.82	2
3	Registered Nurses	6,806	7,631	127,146	16.66	3
4	Licensed Practical Nurses	9,357	10,061	160,877	15.99	4
5	Nurse Aides & Orderlies	39,258	48,393	330,136	6.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,910	6,189	42,298	6.83	8
9	Activity Director					9
10	Activity Assistants	5,337	5,672	48,193	8.50	10
11	Social Service Workers	1,640	4,565	26,247	5.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,092	18,947	150,055	7.92	15
16	Dishwashers					16
17	Maintenance Workers	2,794	2,998	30,908	10.31	17
18	Housekeepers	9,838	11,554	72,944	6.31	18
19	Laundry	7,124	7,744	47,081	6.08	19
20	Administrator	2,232	2,464	49,268	20.00	20
21	Assistant Administrator	658	715	12,922	18.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,822	8,759	90,783	10.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,911	2,222	19,778	8.90	31
32	Other Health Care(specify)					32
33	Other(specify)	1,218	1,269	29,833	23.51	33
34	TOTAL (lines 1 - 33)	121,080	142,690	$ 1,311,721 *	$ 9.19	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 4,561	01-03	35
36	Medical Director	MONTHLY	3,900	09-03	36
37	Medical Records Consultant	MONTHLY	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	1,678	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	39	1,916	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	81	4,510	11-03	44
45	Social Service Consultant	111	3,888	12-03	45
46	Other(specify)				46
47	CONSULTANT REHAB	35	1,343	10a-03	47
48					48
49	TOTAL (lines 35 - 48)	266	$ 25,828		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,374	$ 118,090	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	3,374	$ 118,090		53

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KATHY DONAHUE (1/01-8/01, 12/01)	ADMIN	NONE	$ 29,595
CAREN PERLMUTER (9/01-11/01)	ADMIN	NONE	19,673
ARI SHABAT	ASSIST ADMIN	NONE	12,922
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,190

B. Administrative - Other

Description	Amount
DAN SHABAT-MGMT FEE	$ 205,513
PRO HEALTH-MGMT FEE	6,480
TOTAL (agree to Schedule V, line 17, col. 3)	$ 211,993
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FUTURE ASSOCIATES	ADMINISTRATIVE	$ 54,000
FR&R	ACCOUNTING	57,177
LAWRENCE SCHWARTZ	LEGAL	3,620
PERSONNEL PLANNERS	UNEMPLOYMENT CNSLT	925
ECONOCARE	PURCHASING CNSLT	2,600
SENIOR LIVING SYS	COMPUTER SUPPORT	5,660
LONG TERM COMP SYS	COMPUTER SUPPORT	579
HORIZON HEALTHCARE	COMPUTER SUPPORT	2,089
MARK PAKU	COMPUTER SUPPORT	300
ROGELIO SANCHEZ	COMPUTER SUPPORT	90
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 127,040

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,271
Unemployment Compensation Insurance	10,454
FICA Taxes	100,106
Employee Health Insurance	59,123
Employee Meals	32,412
Illinois Municipal Retirement Fund (IMRF)*	
PENSION CONTRIBUTION	7,781
HOLIDAY EXPENSE	5,314
CHICAGO HEAD TAX	3,480
TOTAL (agree to Schedule V, line 22, col.8)	$ 241,941

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	4,422
Health Care Worker Background Check	
(Indicate # of checks performed 10)	120
IL COUNCIL ON LONG TERM CARE	2,788
LICENSES & FEES	792
ADVERTISING	24,649
Less: Public Relations Expense	
Non-allowable advertising	(24,649)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,322

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	989
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 989

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WATERFORD, THE # 0038612 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NURSES AIDES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LTC-2,788**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,206** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **NA**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES **X** NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
DEAUVILLE HEALTHCARE CENTER, 38612, 11/01/92

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **81,577**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **NA**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NA** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **32,412** Has any meal income been offset against related costs? **NA** Indicate the amount. $ **NA**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **NA**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NA**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NA**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **NA** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NA** If no, please explain. **NA**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees